ATTACHMENT I

FAMILY AND MEDICAL LEAVE ACT FACT SHEET

Eligible employees are provided up to twelve (12) weeks of protected FMLA leave in a 12 month period for certain family and medical reasons.

- TO BE ELIGIBLE:
  - The employee must be employed by Chesterfield County for at least 12 months prior to taking leave (need not be consecutive).
  - The employee must have worked at least 1,250 hours in past 12 months.
- REASONS FOR LEAVE:
  - The employee's own serious health condition;
  - The birth, placement for adoption, or placement of a foster child;
  - The employee's spouse, parent, or child has a serious health condition that requires the employee's care.
- Leave must be requested 30 days in advance, except for unforeseen illnesses.
- Health care provider certification will be required and must be provided no later than 15 calendar days after request.
- Intermittent leave must be granted, if medically necessary, for a serious health condition. Health care provider certification is required.
- In cases of one's own serious health condition, sick leave is used before leave without pay. An employee may choose to use annual leave or floating holiday leave in order to continue in a paid leave status upon the exhaustion of sick leave. Both paid and unpaid FMLA leave are counted toward the 12 week entitlement.
- Current health and dental care coverage will be maintained for the duration of time the employee is out on FMLA leave, with the County paying both the employee and County portions during any periods of leave without pay. The employee's portion of the premium payments will be collected on a pre-tax basis upon the return of the employee from FMLA leave. If the employee fails to return to work after the employee's FMLA leave entitlement has expired (unless for medical disability), the employee must reimburse the County for all of the health benefit premiums the County paid during the period of unpaid FMLA leave.
- In accordance with Administrative Procedure 6-1, Section II (B) accrued sick leave may be used if the employee is unable to work due to an illness or injury incapacitating the employee. If the employee is not incapacitated (Administrative Procedure 6-1, Section II (B), he/she must use annual leave, floating holiday leave, compensatory time, or leave without pay.
- A Health Care Provider statement approving return to work may be required.
- An employee on approved FMLA leave will be restored to same or equivalent position upon return to work.

See Administrative Procedure 6-20 for further details.

ATTACHMENT II

CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993)

1. Employee's Name:	2. Patient's Name (If different from employee):

3. The attached sheet describes what is meant by a "**serious health condition**" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category:

9 Hospital care
9 Absence plus treatment
9 Pregnancy
9 None of the above
9 Chronic conditions requiring treatments
9 Permanent or long-term conditions requiring supervision
9 Multiple treatments (non-chronic conditions)

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

5. State the **approximate date** the condition commenced and the **probable duration** of the condition (and also the probable duration of the patient's present incapacity[1] if different):

6. Will it be necessary for the employee to work only **intermittently** or to work on a **less than full schedule** as a result of the condition (including for treatment described in Item 7 below)? □Yes □No
If **yes**, give the probable duration:

7. If the condition is a **chronic condition**, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:

8. If the condition is **pregnancy**, state the amount of time the employee will be incapacitated after the delivery of the baby:

[1] Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking FMLA leave.

[2] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

CARE FOR EMPLOYEE'S PARENT, SPOUSE OR CHILD

9.a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? _____

c. If the patient will need care only **intermittently** or on a **part-time basis**, please indicate the probable duration of this need:

_____ _____
(Signature of Health Care Provider) (Type of Practice)

_____ _____
(Address) (Date)

_____ _____
(City, State, Zip Code) (Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule: (Attach an additional sheet if necessary.)

_____ _____
(Signature of Employee) (Date)

DEFINITION OF "SERIOUS HEALTH CONDITION"

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care** - Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. **Absence Plus Treatment** - A period of incapacity[2] of more than **three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

(a) Treatment[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(b) Treatment by a health care provider on at least **one occasion** which results in a regimen of continuing treatment[4] under the supervision of the health care provider.

3. **Pregnancy** - Any period of incapacity due to **pregnancy** or for **prenatal care.**

4. **Chronic Conditions Requiring Treatments** - A chronic condition which:

(a) Requires **periodic visits** for treatment by a health care provider or by a nurse or physician's assistant under direct supervision of a health care provider;

(b) Continues over an **extended period of time**, including recurring episodes of a single underlying condition; and

(c) May cause **episodic** rather than continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.)

5. **Permanent or Long-Term Conditions Requiring Supervision** - A period of incapacity[2] which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be **receiving active treatment by, a health care provider.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)** - Any period of absence to receive multiple treatments, including any period of recovery therefrom, by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[2] of **more than three consecutive days** in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

ATTACHMENT III

Request for or Designation of FMLA Leave Form
Under the Family and Medical Leave Act

This form is to be completed by the employee and submitted to supervisor.

Name _____ Soc. Sec. No. _____

Department _____ Phone No. _____

Supervisor's Name _____ Employment Date _____

I have worked for Chesterfield Co. at least 1,250 hours in the past 12 months? ❑Yes ❑No

Purpose of Leave:

To care for an ill parent	For my own serious health condition
To care for an ill spouse	For the birth of a child and to care for that child
To care for an ill child	For placement of a child for adoption or foster care

Note: Health Care Provider Certification is required and is to be attached to this request.

Leave will begin on _____ I anticipate I will need leave until _____

I would like intermittent leave. (Explain schedule desired) _____

For my own serious health condition I want to:

If applicable, use all comp time before sick leave? ❑Yes ❑No
If no, retain _____ number of comp time hours.

Use all annual leave after exhausting sick leave? ❑Yes ❑No
If no, retain _____ number of annual leave hours.

Use all floating holiday leave after exhausting sick leave? ❑Yes ❑No
If no, retain _____ number of floating holiday leave hours.

I have read the attached Family and Medical Leave Act Fact Sheet.

_____ _____
Employee's Signature Date

Approved: _____ _____
Department Director or Designee Date

ATTACHMENT IV

FAMILY AND MEDICAL LEAVE ACT
PLACE ON / REMOVE FROM FMLA FORM

Employee Name _____ Employee SSN _____ Employment Date _____

Department _____ Location Code (8 digit code) _____

Leave Request for: ☐ Employee ☐ Employee's family member

Please note: A Personnel Action Form should be sent to HRM only if the employee goes on a leave without pay status, and again when the employee returns from leave without pay.

PLEASE USE: SECTION A - To report when an employee begins FMLA leave.
SECTION B - To report when an employee is released to return to work on a limited basis.
SECTION C - To report when an employee is released to return to work full-time.

SECTION A

☐ We are placing the employee on FMLA leave.

Leave start date _____ Estimated date of return (if known): _____

The employee elects to:

☐ Use _____ number of comp time hours. Compensatory hours will be used before FMLA leave begins.

☐ Use all annual leave after exhausting all sick leave (for employee's own serious health condition).

☐ Use _____ number of annual leave hours.

☐ The following documentation is attached:
- ☐ Health Care Provider Certification
- ☐ Memo to employee or completed Request for Leave Form

SECTION B

☐ This is to inform HRM that the employee has been released to work on a limited basis.
The effective date is _____

☐ The following documentation is attached: Release to work form (if required)

SECTION C

☐ This is to inform HRM that the employee has returned to work on a full-time basis.
The effective date is _____

☐ The following documentation is attached: Release to work form (if required)

Authorized Signature:

_____ _____
Director or Designee Date

HRM/Payroll Use Only

_____ _____
HRM/Date Payroll Date

12/97